Commonwealth of Massachusetts
Group Insurance Commission

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Group Insurance Commission
P.O. Box 8747, Boston, MA 02114

Application For Insurance Coverage For Retired Municipal Teachers
(Application is subject to eligibility review by the GIC.)

A. APPLICANT INFORMATION

Name _____
Last First Middle Initial

Soc Sec # _____-_____-_____ Sex M ____ F ____ Date of Birth _____/_____/_____

Address _____
Number and Street City/Town State Zip

School System Retiring From _____ Planned Date of Retirement ___/____/___

B. BASIC LIFE AND HEALTH INSURANCE COVERAGE ***Please Read Carefully***

You must include a Beneficiary Form with this application (Form 319 - one to three beneficiaries; Form G-500 - four or more beneficiaries or special designations, such as estate and trusts).

Type of Coverage Desired - *Please check #1 or #2*

1. _____ Life Insurance Only. The amount of coverage has been determined by your city/town/school district. If you choose life insurance only, you will be ineligible to apply for health coverage until the next GIC annual enrollment.

2. _____ Life and Health Insurance - *Choose a-g, checking appropriate box **and** indicate type of coverage*

a) __ Fallon Community Health Plan *check one:* ☐Direct Care ☐Select Care ☐ Senior Plan

b) __ Harvard Pilgrim Medicare Enhance

c) __ Health New England *check one:* ☐ HMO ☐MedPlus

d) __ NHP Care *(Neighborhood Health Plan)*

e) __ Tufts Health Plan *check one:* ☐ Medicare Complement ☐ Medicare Preferred

f) __ UniCare State Indemnity Plan with CIC *(comprehensive) check one:* ☐Basic ☐Medicare Extension (OME)

g) __ UniCare State Indemnity Plan without CIC *(non-comprehensive) check one:* ☐Basic ☐Medicare Extension (OME)

Type of coverage _____ Individual _____ Family

If you are requesting family coverage, the GIC requires a CERTIFIED MARRIAGE CERTIFICATE for your spouse and CERTIFIED BIRTH CERTIFICATES for any other dependents that are to be covered.

C. MEDICARE ELIGIBILITY - YOU MUST PROVIDE THE FOLLOWING MEDICARE DOCUMENTATION:

If you and/or your spouse are enrolled in Medicare Part A and Part B, you will need the following documentation:

- Photocopy of Medicare Card (include a copy of spouse's card if applicable)
- Benefit Verification Letter from Social Security for yourself and/or for your spouse
- Benefit Verification Letter from Social Security must state how Medicare Part B is being paid; if not, also provide photocopy of latest 1099 or a letter from Social Security stating how the monthly Part B premium is paid (include a copy of spouse's, if applicable)

If you and/or your spouse are over age 65 and <u>not eligible</u> for Medicare you will need the following documentation:

- Benefit Verification Letter from Social Security for yourself
- Benefit Verification Letter from Social Security for your spouse

D. FAMILY INFORMATION - *Complete if choosing family coverage.*

1. **Spouse** - *if covered*

Name _____
Last First Middle Initial

Soc Sec # _____-_____-_____ Date of Birth _____/_____/_____

Does your spouse have health insurance coverage _____ Yes _____ No
If yes, Name of Company _____
Address of Company _____
Certificate Number _____

2. **Dependent Children** - *if covered.* Coverage for children ends at age 19 unless they complete and return a *Dependent Age 19 and Over Application for Coverage*, which is approved by the GIC.

Name	Date of Birth	Sex	Social Security #
_____	_____/_____/_____	_____	_____-_____ - _____
_____	_____/_____/_____	_____	_____-_____ - ____

E. DEDUCTION AUTHORIZATION

I authorize my pension authority to deduct from my pension check the amount required for the coverage that I have selected.

_____ _____
Signature Date

*NOTE: Beneficiary Designation Form **must** accompany this application.*

F. CERTIFICATION OF RETIRING TEACHER'S INSURANCE COVERAGE

To be completed by Payroll/Insurance Coordinator

I certify that (name of teacher) _____ is currently covered under our local life and/or health insurance program and will be covered until his/her retirement coverage begins (the 1st day of the 3rd month after the date of retirement), but that I will notify the Group Insurance Commission if coverage is interrupted before the retirement coverage begins.

_____ _____
Signature Date

_____
Please print name and title of position

FOR GIC USE ONLY

Retiree Case # _____ Political Subdivision _____ Agency/Div _____
Effective Date of Ret _____/_____/_____ Name of HP _____
Effective Date of Cov _____/_____/_____ Certificate # _____
Date Approved _____/_____/_____ Authorized Signature_____